STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505309	A. BUILDING _____ B. WING _____	09/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREAGE OF WHIDBEY	311 NORTHEAST 3RD STREET COUPEVILLE, WA 98239

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This report is the result of an unannounced Off-Hours Quality Indicator Survey (QIS) conducted at Careage of Whidbey on 9/15/13, 9/16/13, 9/17/13, 9/18/13, 9/19/13, and 9/20/13. The survey included data collection on 9/15/13 from 2:00 p.m., until 6:00 p.m. A sample of 36 residents was selected from a census of 95. The sample included 28 current residents and the records of 8 former and/or discharged residents.

The survey was conducted by:

[redacted] R.N., BSN
[redacted] BSHS
[redacted] R.N., BSN

RECEIVED
OCT 10 2013
ADSA/RCS
Smokey Point

The survey team is from:

Department of Social and Health Services
Aging and Long Term Support Administration
Residential Care Services, Region 3, Unit B
3906 172nd Street NE, Suite 100
Arlington, WA 98223

Telephone: (360) 651-6850
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Roberta Crawford 9/26/13
Residential Care Services / Date

Submission of the Response and Plan of Correction is not a legal admission that a deficiency exiists or that this Statement of Deficiency was correctly cited, and also not to be construed as an admission of of interest against the facility the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preporation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation bythe survey agency. Accordingly, the facility has prepared and submitted this plan of correction soley because of the requirements under state and federal law that mandate submission of a plan of Correction within ten (10) days of the survey as a condition to participate in the title 18 and Title 19 programs. The submission of the Plan of Correction within this time frame should in no way be considered or construed as agreement with the allagations of non-

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	10/8/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain a home-like environment in dining rooms and corridor doors leading to the outside. This failure had the potential to lessen the quality of life for the residents residing in the facility. Findings include, but are not limited to: REHAB DINING ROOM During observations on 9/18/13 from 8:37 a.m. until 9:00 a.m., Staff G, a nurse was observed with her med cart in the dining room, dispersing medication to residents seated for the morning meal. Resident 190 and an unidentified male resident seated at a table were overheard to make a comment "It's just like a damn hospital in here!" "I would like to eat one meal in peace." referring to an interruption to take his medication. Observations on 9/19/13 starting at 8:30 a.m. revealed the same nurse with her med cart in the dining room. The same observations were made on 9/20/13 from 8:00 a.m. until 10:00 a.m. EAST DINING ROOM During observations on 9/16/13 starting at 12:18 p.m. Staff I, a Nursing Assistant (NAC) was	F 252	(con't) compliance or admissions by the facility. The nurse who had her medication cart in the dining room was educated on not brining Med. carts into the dining area. Licensed nursing will be inserviced on not bring Medication carts into the dining area. Compliance with this will be done by nursing floor managers, DNS and Administrator. Residents upon admission are requestedto review our medication consent form. This form notifies our staff if a resident agrees to or would prefer not to receive medication during meals. Residents who decline are not offered medication during meals.	11/1/13

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F 252	Continued From page 2 standing over a resident and placing food in the resident's mouth. After several minutes, the Director of Nursing Services came into the room and instructed the NAC to sit down and assist the resident. WEST DINING ROOM Dining observation on 9/16/13 at 1:00 p.m., revealed the resident's meals were served on trays. This added to an institutional feeling of the environment. MAIN DINING ROOM Observations on 9/16/13 at 12:37 p.m. revealed Staff J, a NAC to be standing over a resident while feeding her.	F 252	Nursing staff will be inserviced on sitting down with residents when assisting with meals. Floor managers, DNS and Administrator will monitor meals for compliance.	11/1/13
	CORRIDOR DOORS During all days of observation, emergency exit doors located at the end of each corridor had torn, Christmas paper covering the window panes. When interviewed on 9/18/13 at 2:45 p.m., the Director of Nursing Services (DNS) stated it was to block the view to the outside, as a confused resident had been trying to exit the doors. The DNS acknowledged the paper looked "tacky" and curtains were planned to be installed in the future.		Prior to survey Administratorhad received a consult from an interior window consultant and blinds have since been ordered for windows on emergency exit doors. They will be installed before Nov. 15th, 2013 Administrator will monitor for compliance.	11/15/13
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323	Continued From page 3 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide necessary supervision for 1 of 1 residents (75) who smoke. Failure to assess the resident for independent safe smoking placed him at risk of harm. Findings include: Resident 75 readmitted to the facility in [redacted] 2013. Diagnoses included effects of a stroke with right sided weakness, a fractured left [redacted], and uncontrolled diabetes. On 9/17/13 at 9:00 a.m., the resident was observed sitting in a motorized wheelchair, across the street from the facility. When interviewed that same day at 11:30 a.m., the resident informed the surveyor the facility told him he had to leave the property to smoke. "When I go out in the evening, they got me this reflecting tape to put on my wheelchair so cars will see me when I go down the driveway and cross the street." When asked what he would do if he ran into trouble, the resident stated he had a cell phone with a flashlight and the phone worked "sometimes."	F 323		

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F 323	Continued From page 4 A review of the resident's record on 9/17/13 indicated the resident had been found unresponsive and slouched in a chair earlier that same morning related to a hypoglycemic episode (where the resident's blood sugar was recorded at a low of 44). An acceptable range of a normal blood sugar is between 68 and 176. Further review of the resident's record revealed blood sugars during the previous week were as high as 251 and as low as 40. Additionally, a review of the incident/accident log indicated the resident had suffered a 2nd degree burn related to a hot beverage and his inability to control hand tremors. The facilitie's smoking policy was reviewed on 9/17/13. It provided conflicting information as it stated "Careage of Whidbey is a smoke free facility. An area in the courtyard is provided for both residents and staff. Any resident who smokes will be individually assessed and the appropriate care plan will be implemented." The smoking assessment was not found in the resident's record. The administrator was interviewed the same day at 11:50 a.m. He acknowledged he was aware the resident was going off the facility property to smoke as it was the policy of the facility to not allow any smoking on the property. However, employees could smoke in their vehicles. He stated he had concerns for the resident's safety.	F 323	This facility remains a non-smoking facility. Any resident that does not comply with this facility policy will be givin a discharge notice in compliance with state regulations. Durinq the discharge period the resident will be assessed for safety and the facility will ensure the residents safety until discharge takes place. This will be monitored for compliance by the floor managers, DNS and Administraot.	10/8/13
F 371	483.35(i) FOOD PROCURE,	F 371		

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F 371 SS=E	Continued From page 5 STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure that food was stored, prepared, distributed and served under sanitary conditions for 3 of 4 dining rooms. This placed residents at risk for potential food borne illnesses. Findings include: EAST DINING ROOM /HALL TRAYS On 9/16/13 at 12:08 p.m., an uncovered food cart was placed next to a soiled linen hamper in the hall. Several staff members were observed to walk by the uncovered cart, and one staff member placed a bag of clothes in the hamper. At 12:15 p.m. the cart was moved into the dining room. At 12:20 p.m., Staff D, a Nursing Assistant Certified (NAC) brought a resident into the dining room and began pouring liquids into several cups. With bare hands, Staff D was touching the rims of several cups without washing her hands. On 9/18/13 at 8:22 a.m., two food carts were	F 371	9/17/13 The soiled linin carts near the entrance to the east dining room have been moved to a new location away from the dining area. Signs have been posted near the entrance stating "No linin or trash bins in the area" Nursing floor manager, DNS and Administrator will ensure compliance. Staff member was individually inserviced on 9/20/13 on food handling and handling of serving utensils. All staff will be inserviced on proper handling of serving utensils and dishes. This will be monitored for compliance by the nursing floor managers, DNS and Administraor.	9/17/13

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F 371	Continued From page 6 observed to be uncovered next to a soiled linen hamper. One of the carts had two trays of partially uncovered food. During a fifteen minute observation, various employees disposed of bagged clothing into the soiled linen hamper. At 8:34 a.m., Staff A, a Resident Care Manager, stated the food carts should not be placed next to the soiled linen hamper. The food carts were immediately moved and two new food trays were ordered. MAIN DINING ROOM On 9/16/13 at 12:33 p.m., Staff B, a NAC, assisted a resident by moving the wheelchair closer to the table and cutting up the food. The NAC offered the resident a drink of fluids by touching the rim of the glass with her bare hands, and proceeded into the kitchen to retrieve another food tray. She was not observed to wash her hands. On 9/20/13 at 10:10 a.m., the Director of Nursing Services (DNS) stated staff should not touch the rim of cups when serving or assisting residents with their fluids. REHABILITATION DINING ROOM On 9/16/13 at 12:10 p.m., the steam table was delivered by the kitchen staff. Several staff members were observed to touch the lids and serving utensils with their bare hands. At 12:24 p.m., a NAC began preparing to serve the lunch meal by touching the same serving utensils and lids of the steam table and then grabbing pieces of bread with her gloved hands. At 12:30 p.m., she removed her gloves.	F 371	10/8/13 Staff member B was individually inserviced on handling of serving utensils and dishes. She also received individual inservicing on handwashing. 9/16/13 on 9/16/13 after DNS was notified of observation nursing staff in Rehab unit were inserviced on proper handling of serving utensils and proper food handling techniques	

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F 371	Continued From page 7 On 9/18/13 at 8:12 a.m., Staff C, a NAC, was in the dining room passing beverages. Staff C was observed with gloved hands touching the trash can lid and then proceeded to butter toast, handling the lids and serving utensils on the steam table, and opening various drawers in the dining room. The surveyor stopped the NAC at 8:20 a.m. and discussed the above observations. She removed her gloves and washed her hands. On 9/19/13 at 8:45 a.m. the DNS stated all NAC's in that dining room had food handler permits and the staff member should have changed her gloves in the above situation.	F 371	On 9/16/13 Trash bins were removed and replaced with trash bin that does not have a lid, and will not require and touching to dispose of items. Floor managers, DNS and Administrator will monitor and ensure compiance.	9/16/13
F 387 SS=E	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure timely	F 387	Medical Record Coord. will continue to send out reminder notices to all Physicians with dates that they must see residents. This same list will be provided to DNS and Administrator. Medical Director will contact Physicians who are out of compliance. DNS and Administration will monitor and ensure compliance.	10/4/13

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F 387	Continued From page 8 physician visits for 14 of 95 residents. This failure placed the residents at risk of having inadequate medical supervision of their care. Findings include: On 9/19/13 residents records were reviewed for timeliness of physician visits. On 9/20/13 at 11:00 a.m., Staff E, Medical Records Coordinator, was interviewed regarding physician visits. Staff E identified 14 residents with no physician visit in over 60 days. Staff E sent a reminder to the physician on 9/9/13 and verified the physician had not seen the residents. At 11:10 a.m., the Director of Nursing Services confirmed the delay in physician visits.	F 387		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441		

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F 441	Continued From page 9 (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to implement an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development of transmission of disease and infection. This failure had the potential to compromise the resident's health and ability to maintain or reach his or her highest practicable level of well-being. Findings include:	F 441		

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F 441	Continued From page 11 ENVIRONMENT Multiple observation were made from 9/16/13 to 9/18/13 of an incentive spirometer (a device used to help residents improve the functioning of their lungs) tipped over on its side with the mouthpiece lying directly on a table in the rehabilitation dining room. A resident's name was on the device. On 9/18/13 at 1:45 p.m., Staff G, a nurse was interviewed regarding the incentive spirometer. She carried it to a resident's room and then brought it out again. She then placed the incentive spirometer on her med cart, with the mouthpiece firmly against the surface. When interviewed on 9/18/13 at 3:50 p.m., the DNS indicated it was against facility policy to have the spirometer in the dining room or laying on a nurse's med cart.	F 441	Licensed nursing staff will be inserviced on proper handling and storage of spirometers, and/or equipment with mouth pieces. DNS and Floor managers will monitor for compliance.	11/1/13
F 494 SS=B	483.75(e)(2)-(3) NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation	F 494		

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F 441	Continued From page 10 HAND HYGIENE On 9/16/13, multiple observations were made of Staff F, a maintenance worker answering resident's call lights, picking up items from the floor, touching a toilet, adjusting cables in a dining room and going in and out of resident rooms without changing his gloves. On 9/16/13 at 11:40 a.m., the Director of Nursing Services (DNS) was informed of the above observations. The DNS stated the employee should have changed his gloves and would be in-serviced immediately. On 9/16/13 at 12:10 p.m., the steam table was delivered by the kitchen staff to the rehabilitation dining room. Several staff members were observed to touch the lids and serving utensils with their bare hands. At 12:24 p.m., a NAC began to prepare to serve the lunch meal by touching the same serving utensils and lids on the steam table and then touch bread with her gloved hands. On 9/18/13 at 8:12 a.m., Staff C, a NAC, was in the dining room with gloved hands passing beverages. She was observed pushing open a trash can lid wither her hands. She proceeded to butter toast, handle the lids and serving utensils on the steam table, and open drawers in the dining room. The surveyor stopped Staff C at 8:20 a.m. and discussed the above observations. Staff C washed her hands and changed her gloves. On 9/19/13 at 8:45 a.m. the DNS stated the staff member should have changed her gloves and washed her hands in the above situation.	F 441	9/16/13 After DNS was notified on 9/16/13 of observation of staff member "F" he was individually inserviced the same day on "use of gloves". This will be monitored and ensured for compliance by the Maintenance dept., DNS and Administrator. All staff will be inserviced on proper hand washing tech. and facility hand washing policy. This will be monitored and ensured for compliance by Floor managers, DNS and Administrator.	11/4/13

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F 494	Continued From page 12 program, or a competency evaluation program approved by the State as meeting the requirements of §§483.151-483.154 of this part; or that individual has been deemed or determined competent as provided in §483.150(a) and (b). A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in §488.301 of this chapter. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to monitor and comply with regulations pertaining to the number of days worked by Nursing Assistants, Registered (NAR). The failure to monitor and remove NARs that had not successfully tested, and, or were not certified after 120 days of work, placed all residents at risk for receiving less than optimal care. Findings include: A Nursing Assistant-Registered (NAR) is a nursing assistant who has registered with the Washington State Department of Health. A Nursing Assistant-Certified (NAC) is a nursing assistant who has completed an approved nursing assistant training program and passed a	F 494	11/1/13 The facility has requested a waiver of the 120 day requirement for F-TAG 494. Current systems in place to attempt to stay in compliance with this requirement will continue to be in effect. NA's will complete and turn in required paperwork to get a test date on the day they have completed the CNA class. Staffing Coordinator, DNS and Administrator will monitor to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505309	A. BUILDING _____ B. WING _____	09/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 494	Continued From page 13 written and skills exam. During a review of facility credentialing for Nursing Assistants on 9/19/13, a total of 11 nursing assistants (NAR) who were currently working at the facility for more than four months were not listed as Nursing Assistant-Certified with the Washington State Department of Health. Additionally, 5 of the NARs were observed to be working on 9/18/13 and 9/19/13. During an interview with the Administrator and Director of Nursing Services on 9/19/13 at 3:35 p.m., the Administrator acknowledged the facility was delinquent in requiring the necessary credentialing.	F 494		